

Name of agency personnel who prepared this claim.							
Name:	Phone:						
Nancy Thomas	233-3559						

INSTRUCTIONS: This agency is requesting disclosure of your Social Security Number in accordance with I.C. 4-1-8.

VENDOR INFORMATION					AGENCY INFORMATION				
Document Number Date (month, day, year)				v, year)	Name of agency				
					Lieutenant Governor's Office				
Name of vendor					Agency Number 038				
Address (Number, Street)				Social Security Number			1099 CODE		
Address (P. O. Box Number)					Federal I. D. Number	1099 CODE EX			
City, State, and ZIP Code (00000-0000)					Vendor Number				
AREA BELOW TO BE COMPLE									
DA	TE	AMOUNT	FUND	OBJECT	CENTER	LOAN/INV/NBR	QTY.	UNIT	DESCRIPTION
			6000	572500	113800				
GROSS AMOUNT \$				Furnished to: (Name of State Agency)					
I certify that this claim is correct and valid and is a proper charge against the State Agency, Fund, and Center indicated.									
					Date (month, day, year)				
Pursuant to the provisions and penalties of Indiana Code 5-11-10-1, I hereby certify that the foregoing Fund and Center is just and correct, that the amount claimed is legally due, after allowing all just credits, and that no part of the same has been paid.									
Signature of Vendor				Date (month, day, year)					